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Original Lectures.

AORTIC STENOSIS AND PHTHISIS PULMONALIS.

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There is no theme so old but it can be rejuvenated by a new touch of light; just as no conceit of man is so new but it may turn out that the discovery of to-day was only the lost treasure of yesterday.

In our species, the interdependence of cardiac and pulmonary pathology is a well-recognized fact and one of great import in clinical work. It will occur to no one to deny the etiological influence of mitral regurgitation on the development of chronic bronchial catarrh, though we may, perhaps, be inclined to neglect the material bearing of primary bronchial catarrh upon the right side of the heart.

No one will deny that pneumonia and pleurisy will develop and run their course in chronic heart-sufferers in a peculiar way, and that they involve consequences of their own. But it is questionable whether the subject of relationship between pulmonary phthisis and cardiac disease has ever been approached with any degree of thoroughness.

Of all the orificial lesions of the heart the obstruction of the pulmonary outlet is the only one that has been incriminated with a working influence on the production of tuberculosis of the lungs. No doubt can be entertained on that score after the overwhelming amount of proof, both clinical and autopsical, that has been adduced by such clever observers as Lebert, Constantine Paul, Norman Chevers and others.

The other three orifices, namely the aortic, the mitral and the tricuspid, have, as it were, run the gauntlet of innumerable searching professional eyes, opened on their doings without creating even a ripple of suspicion. And it is rather amusing that the advocates of the phlogistic theory of phthisis should have inflicted a snub on the mitral valve, when it was contriving so hard to work in a line with their hypothesis by crowding the lung with blood.

The first shadow of suspicion that it might be different with the aortic orifice occurred to me some ten years ago while attending a cardiac patient in Nice, France.

The subject was an English lady, in fact an old maid, of the typical form and manners. She had made the sunny South her winter home ever since a severe attack of inflammatory rheumatism, which she had contracted some twelve years prior to the epoch of my observation of her case. In spite of her many scruples and objections, with considerable strategy I had managed to discover and make sure of the presence of a marked hypertrophy of the left ventricle, which taken in conjunction with a loud systolic murmur, propagated to the vessels of the neck, and a slow, small but wiry pulse unmistakably pointed to aortic stenosis. There were also present clinical symptoms that were evidently due to a defective circulation, such as cold hands and feet and occasional spells of giddiness. But her most troublesome ailment was an obstinate insomnia which spigelia alone could relieve. One October morning two days after her arrival from England she sent for me. I was struck with the change in her appearance. Her face was pale and wan, while her figure seemed thinner than ever.

She told me that during the summer she had had two attacks of hemorrhage, one of them being very severe. The blood was bright red and frothy. She had been losing strength steadily, and complained of a loose cough accompanied by some yellowish sputum.

On examination I found the breathing pretty nearly normal elsewhere, save in the left inter-scapular region, which exhibited numerous moist crackling rales. No doubt the lung was undergoing the process of tuberculous softening. On turning my attention to the heart I then noticed that the hypertrophied ventricle was larger than ever, but that it had lost some of its energy. The prognosis was a gloomy one, and in spite of all I could do the hectic symptoms grew apace, the heart giving way in the meanwhile, and she died early in the spring of the following year.

I confess that the etiology of this case of phthisis puzzled me at the time. It was the first time that I had observed tuberculosis of the lung in a cardiac subject, and the strange co-existence of two diseases which I had thought to be antagonistic, unsettled one of my beliefs. I had heard Guéneau de Mussy express the opinion that rheumatic, asthmatic and cardiac subjects need have no fear of consumption, and the authority was a good one.

The same summer while visiting the "Polyclinique" of Vienna, for the purpose of practicing auscultation and percussion, I stumbled on a case which recalled forcibly to my mind the one just related. The subject was a man of about 40. He had entered the hospital to seek relief for a dry cough which had been troubling him for the last two months. After severe spells of coughing he would raise some whitish mucus streaked with bright red blood. While examining his lungs I discovered a murmur in the right interscapular region, together with some pronounced broncho-vesicular breathing, a few crackling rales, and some sibilant breathing.

The percussion-note was decidedly high over the same region. The opposite side was normal. I had no trouble in tracing the murmur to the heart. It was a systolic mur-

mur, propagated upwards, and by careful investigation I noticed that it was followed by a faint diastolic murmur. The heart-impulse was heaving, though the apex-beat was indistinct, the area of præcordial dullness being considerably increased. Here was a clear case of aortic stenosis, combined with a slight degree of aortic insufficiency, showing signs of a focus of tuberculous consolidation. The man said there had never been any consumption in his family. I left Vienna some weeks afterward, and I do not know what finally became of the case. I did not give much thought to the subject at the time. After all it might simply be a question of coincidence, a mere pathological curiosity.

It was not until two other cases came under my care in the clinic-room of the Hahnemann Hospital that it occurred to me that there might be a more intimate relationship between the cardiac difficulty and the pulmonary affection. I will read the history of these cases for the benefit of the class:

Case 19,363. (August 11, 1888.) Mrs. Katie S., age 22, complains of pain and soreness all over the chest, which grows worse when she takes cold. She is troubled with a cough and palpitation of the heart, and the sputa that she raises is streaked with blood. She is nursing a two-month's child, but has not enough milk for it. She had rheumatism when she was 9, and again when she was 11 years old.

Physical examination reveals an exaggerated heart-impulse and increase of the superficial area of cardiac dullness, a double aortic murmur, one of which, the systolic, is much louder than the diastolic, and is plainly heard at the angle of the left scapula. Both ventricles seem enlarged. There is some irregularity of the rhythm of the heart. The breathing presents a marked broncho-vesicular character at both apices. The percussion tone is somewhat impaired.

The diagnosis was plain: Aortic stenosis and regurgitation, with suspicious apical catarrh. The remedies were cactus grand. and calcarea carbonica.

August 18. She feels better, but complains of a dull pain in the left hypochondrium. The heart's action is more regular. Same prescription.

August 25. There is a sore feeling across the chest when coughing. Naja and calcarea carb.

Sept. 7. The pain in the left side is entirely gone. The action of the heart and the cough are much improved. Naja and calc. carb. were continued, but to be taken at longer intervals. The patient did not reappear at my clinic until February 9, 1889. She has been well up to within two weeks, when she caught cold. She now complains of sore throat; at the same time the old soreness of the chest has come back; besides there are at times suffocative attacks after exertion, which are frequently followed by a dry cough.

On examination I find no perceptible change in the condition of the heart and the intensity of the murmurs. But the apices exhibit quite a change for the worse. There are quite a number and variety of dry and moist rales, and high-pitched sibili on deep inspiration. The percussion note is markedly dull, especially on the right side. Phosphorus.

March 2. Has caught a fresh cold. The pulse is full, bounding and frequent. She does not complain of any discomfort from the heart. But she coughs more and there are signs of limited pulmonary congestion. Aconitum.

This patient has never returned, and I very much fear that by this time she must have succumbed to the progress of lung tuberculosis.

Case 19,388. December 26, 1888, Miss Lena S., from Elgin, Ill. Age 19. The patient is a girl of weakly appearance. Her face is very pale. She has been ailing for the past six months with a pain in the region of the heart, extending to the stomach and occasionally to the left scapular region. She coughs a good deal and raises a thick yellow sputum. Has had repeated attacks of acute rheumatism in the left arm. She also formerly used to have severe nose-bleed. She has menstruated very irregularly, and since the beginning of her illness has lost flesh steadily. There is no tuberculous family history.

Physical Examination. Strong heart-impulse. The apex-beat is found in the sixth interspace, displaced two inches to the left. A very loud systolic murmur is heard at the base of the heart, which can be followed in the arteries of the neck, and is very distinctly perceived over the whole thorax, though with greater intensity over the left interscapular region. The second aortic sound is muffled. The

apices in front give way to a poor percussion tone, and expand feebly. Posteriorly there is quite a dullness over both inter-scapular regions, and the breathing is pronouncedly broncho-vesicular, with a good deal of jerking both in inspiration and expiration. At times the systolic murmur is so loud as to overshadow the breath sound. The pulse is 90 and weak. The fingers are clubbed, and the patient says that the change has taken place within a few months. Spigelia and calcarea phosphorica.

The diagnosis was plain enough. I explained to the class how such a systolic murmur, extending upward into the neck, with its maximum at the base of heart, taken in conjunction with such manifest ventricular hypertrophy could only mean *aortic stenosis*, while all the stethescopic signs derived from a careful examination of the lungs pointed to a bilateral infiltration of tubercle at the level of the scapula.

As to prognosis, with my experience of such cases, I could only pronounce it very unfavorable, especially as both lungs were affected and over a pretty extensive area. Softening might set in at any time and the destruction of tissue would be such as to involve a speedy termination of the drama.

The patient kept calling at the clinic until January 3, 1889, with no decided improvement. She had a raw, scraping cough, and pain had developed in the right lung. She complained of a soreness across the stomach and frequently would suffer with headache. She had no appetite, but was thirsty. Arsenicum.

This was the last we saw of her, as she called no more.

Now, if we seek the philosophy of the foregoing cases, we may well ask ourselves whether the relation between the cardiac and the pulmonary lesion is causative or merely accidental. I confess that I am strongly inclined to accept the former hypothesis.

Let us consider for a moment the circulatory conditions created by the aortic lesion in the lung parenchyma. The first result of the constriction of the aortic orifice is that a smaller blood-wave is propelled into the aorta, and as a natural consequence the blood will not easily enter those vessels that branch off at a broad angle from the main cur-

rent. Such is known to be the case in the nutrient vessels of the lung, namely the bronchial arteries.

Very likely, so long as the compensatory hypertrophy of the left venticle holds good, the tone of the blood-pressure in the arterial system will be equal to the task of driving the life-bearing fluid into all the organs, and although the absolute quantity thereof that is supplied to the tissues in a given time will be of necessity diminished, the vital resources are such that the organism is seen to adapt itself to the parsimonious fare.

A curious result of that faculty of adaptation evinced by the organism is the marked shrinkage of the aorta and of its main branches which the *post-mortem* examination of cases of aortic stenosis rarely fail to exhibit. It is owing to the same faculty that the shrinkage of the small intestine is observed in stenosis of the pylorus.

It is therefore permissible to conceive that as soon as the compensation weakens, or whenever the ventricular energy is enfeebled by some intercurrent disease, the nutrition of the badly irrigated organs suffers, and that a condition of local hypertrophy, or of defective nutrition sets in, lowering the tone of vital resistance in the affected parts. The lung is particularly exposed to that danger on account of the anatomical disposition of its nutrient vessels. No wonder, then, that it should be open to tuberculous infection when such favorable soil is offered to the inroads of the ever-active and ever-present bacilli.

It is evident, moreover, that any latent predisposition, hereditary or otherwise, will be brought to a climax by the conditions above described.

As a collateral instance of the important part played by the arterial supply of the lung in the genesis of tuberculosis, I shall briefly cite the case so graphically described by Jaccoud in his "Lecons Cliniques," where atheroma of the aorta and of its thoracic branches was recognized as the primary cause of phthisis and of death. The subject was a strong workman with all the appearance of perfect health. One day, while in the act of running for a car, he felt a vio-

lent pain in the chest that obliged him to stop. At the same time a profuse quantity of bright-red blood escaped from his mouth. He was brought to the hospital and placed under Jaccoud's care. For several days his life was jeopardized by severe attacks of bronchial hæmorrhage. When it became possible to examine his chest, a limited hæmoptoic focus was found in the left lung. Investigation of the præcordial region revealed a marked cardiapathy with aortic lesions and an atheromatous condition of the aorta. After a while pneumonia set in at the site of the hæmoptoic focus, which the patient weathered bravely, but the resolution was never complete, and shortly afterward unmistakable signs of tuberculization appeared and the patient died three months after the first hemoptysis with all the symptoms of pulmonary consumption. The autopsy revealed advanced atheromatous changes in the aorta and all its thoracic branches; the bronchial arteries were markedly altered, their calibre being narrowed, and it was the bursting of one of their ramuscules that had caused the bronchial hæmorrhage. No doubt that prior to that accident, the indirect consequence of which alone proved fatal, a condition of hypertrophy of the lungs must have been present which only needed a fortuitous occasion to favor bacillary invasion.

Summing up the clinical teaching contained in the foregoing cases, I feel warranted in saying:

1. That the alleged antagonism between rheumatism and tuberculosis may be considered as a myth; on the contrary it would rather appear from recent observations that the early rheumatic manifestations of young people are naught but the forerunners of tuberculosis.

2. That the obstruction to the normal flow of blood from the left ventricle into the arterial system is apt to create favorable conditions for the invasion of tuberculous germs, though in a lesser degree than the obstruction of the pulmonary orifice.

3. That the prognosis of such cases is very unfavorable, inasmuch as the patient stands in a vicious circle, on one

hand the aortic difficulty interfering with the proper nutrition of the lung tissue, and the tuberculous poison on the other hand tending to bring about rapid steatosis of the heart-muscle.

It is the province of every practitioner to derive from these premises such hygienic and therapeutic inferences as his experience and conscience may suggest. I can say, however, that sulphur in the higher dilutions, being perhaps our best remedy in the early manifestations of rheumatism, as well as of tuberculosis—curiously enough—we might resort to that powerful though dangerous metalloid. Dangerous indeed in tuberculosis, for if it be administered indiscriminately, that is *when there are any actual physical signs present, even the earliest*, it will precipitate matters.

VASO-MOTOR NERVE DISTURBANCES DURING THE CLIMACTERIC.

PART I.

By Prof. E. Stillman Bailey, M. D.*

The scope of this paper shall be to consider the disorders rather than diseases of the menopause, and to limit them to those directly influencing the varied phenomena of the vaso-motor nervous system. In this critical epoch of woman's life, "the change" is regarded with apprehension and fear. It is not a disease, but it simulates a host of diseases. None of the symptoms that are so common are better known or more frequently emphasized than the hot flashes. It is known that they are not dangerous symptoms, but they are often alarming, not because of what they realiy are, as that they may foretell more dire things to follow. The "freezing" symptoms that some-

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times follow the hot flushes, are also annoying and alarming to the patient.

The universality of these symptoms often give to the patient the idea that these things must necessarily be, that all women must suffer alike, and that for many months the hot flashes will come and go, and, possibly, the whole train of symptoms connected with the change may have a sudden ending, either in recovery or in death.

The few, out of the many symptoms of this period that come under the head of the disorders that I wish to speak about and refer to in the way of treatment, are the irregular flushings of the face, the concomitant pallor, the sudden changes in the temperature of the extremities, and the general irritability of the nervous system, especially in the derangement of functions dependent upon the nerve control of the greater plexuses, like the solar or lumbar.

In point of fact women do not suffer alike in the post-cessation menstrual affections. Some have exhaustive hemorrhages while others escape; some have mental disturbances and others find their chronic headaches disappearing; some are tormented with vesical irritation, pruvitus vulvæ, back-ache and loin-ache, gastralgia, flatulence, capricious appetite and nervous dyspepsia, while others discover that these ills so common to them for many years are fading away, and the dawn of a healthy day is upon them. Hysteria with its army of a thousand symptoms yields to a well-mannered and well-ordered life. By way of a short trespass let us remember that the vaso-motor system of nerves controls the calibre of the blood vessels. It contracts and it dilates them. It is the equilibrium of these two movements, upon which the ebb and flow of the blood current depends, and waste and repair is adjusted. Local or general anæmia or hyperæmia follow the disturbances of the circulation. Hence there is a more or less constant change in the circulation within certain health limits, but where there is a constant anæmia or hyperæmia, disorders pass to diseases. The womb and its annexes being exacting organs in menstrual life, it follows very easily that these

parts bear the brunt of the circulatory disturbances. Active neuroses then follow with either local or reflex symptoms, which for the time mimic structural lesions. From this reflex irritability comes spasms of the circular fibres of the blood vessels of variable calibre. These spasms when continued, seriously interfere with nutrition of parts, and a veritable neurotic lesion supervenes.

The intimacy of the vaso-motor-system is so great with the fibres of the sympathetic and the cerebro-spinal systems, that local disturbances ere long become general and systemic. It is a difficult matter to say just where the physiological symptoms leave off, and the pathological ones begin. The tone of the general arterial and capillary circulation is under the control of the vaso-motor centres in the medulla. Yet there are numerous centres in the gray matter of the spinal cord, and it is the connection between these centres and the ganglia in the arterial walls that we are most interested in, for the firbes pass partly through the rami-communicantes to the sympathetic ganglia, and thence to the arterial walls, and partly in a direct course through the anterior roots of the spinal nerves to the intra-mural ganglia. These centres are of two kinds : the vaso-constrictors, and the vaso-dilators ; normal stimulation of which, causes contraction or dilatation of the vessels respectively. Just how this stimulation to the periphery is applied, is not settled, even theoretically, by physiologists ; the latest theory being that the function is performed through the ganglia situated in the arterial walls, rather than direct action upon individual fibers.

It is a common statement of authors upon the subject of diseases during the menopause, that those patients who suffered most at the time of the establishment of puberty, are the ones most liable to disturbances at the climacteric, and that the functions of the skin are at both epochs most frequently involved.

The outline of the disturbances as given above, that I refer to, are strictly vaso-motor, and not functional or pathological, except as pathologists now explain the hot flashes,

the pallor, the changes in the temperature of the extremities, and the spinal irritability, as one phase of a veritable multiple neuritis. The burning heat at the vertex, is not infrequently accompanied with a coldness of the feet and legs as far as the knees. These sensations come from pathological changes in the distal extremity, or segment of the ganglia distributed to the ultimate cell element, and are atrophic in character. In the one, the refrigerent nerve is irritated, the other, the vaso-dilator. The one creates a disturbing element of heat, the other destroys the heat distribution to the surfaces, and there is chronic coldness with attending suffering.

In the numbness of the fingers and the prickling condition of the skin of the face, hands, trunk and feet, if the period of "the change" be prolonged for many months, an intermittent paralysis of the governing nerve, or plexus takes place. The pathological changes of the multiple neuritis, in this class of cases, are atrophy and distal degeneration of the nerve fibre, or else they are to come under a recent enumeration, as made by Prof. Starr, who claims that the subjective symptoms clinically encountered in the hot flashes, the numbness, pain, formication and muscular weakness arise from sub-acute inflammatory conditions of peripherpal nerves, and are independent of spinal lesions or "functional neuroses."

The nerves seem affected only in their distal portions and that the sensory and motor fibres are equally affected, hence the multiplicity of symptoms. Again to this same pathologist we are indebted for the information, that in multiple neuritis, degeneration of the nerve-fibre, as a rule, is an extremely slow process. "From six to eighteen months may be required to ensure a complete restoration of a nerve after the fibres have been seriously impaired by a degenerative process." If true, this may be the solution of the long or short period of hot flashes.

I might point out many of the graver symptoms occurring at the menopause that would better come under the heading of neurasthenia, or nerve exhaustion, but this one

class of symptoms must suffice for this paper. What will relieve and what will cure? There is hardly any disorder, that is so fruitful of symptoms as the active neuroses of the uterine group of nerves. Nature is discontinuing a function of many years' duration. The changes are atrophic and inflammatory. We cannot group a class of remedies that will be exhaustive and alone useful. Many domestic remedies are invaluable, and are such as are handed from one patient to another while passing through the change. They need not be discouraged. It is known by clinical evidence that a regeneration of a diseased nerve is hastened by particular attention paid to its peripheral distribution, hence mechanical attention to the surfaces of the body are valuable. I can recommend for the vaso-motor disturbances of the extremeties, that they be daily immersed in a hot salt-water bath (110° to 120°) for thirty minutes at a time; also that friction of the parts involved be made several times a day, preferably with the hand or the rough towel. Massage and passive movements are also valuable. Electricity I especially recommend as an extremely valuable adjunct to the treatment. The physiological effects of this agent are indefinite, but the excellent clinical results in many cases cannot be denied. In fine, it seems that the advances of the modern electro-therapeutics are meeting a class of cases hitherto shunned or neglected. As to its manner of use, the individual case must settle it, but Müller's formulation of use—"weak currents and short sittings"—seems to be accepted by electro-therapeutists, or at least it is the formula looked upon with great favor.

I am also a believer in the administration of homœopathically selected remedies, and I have found the following to assist very materially in this class of cases: Aconite, actea racemosa, amyl nitrosum, aurum metallicum, ferrum metallicum and ferrum phosphoricum, gelsemium, glonoine, sanguinaria, sepia, sulphur and lachesis.

Clinical Society Transactions.

HOWARD N. LYON, M. D., SECRETARY.

JUNE MEETING, 1890.

The regular monthly meeting of the Clinical Society was held in parlor 23 of the Grand Pacific Hotel, Saturday evening, June 28, President Barrows in the chair. Twenty-five members and a number of visitors were in attendance. After the routine business was disposed of, came the reading of the

REPORT OF THE BUREAU OF CLINICAL HYGIENE.

DR. J. E. GILMAN, CHAIRMAN.

CERTAIN CAUSES OF SUDDEN DEATH.—By J. E. GILMAN, M. D.—The startling frequency with which case after case of sudden death has shocked the community, gives us reason to ask what are the causes of the comparatively considerable increase in this direction.

An occasional victim here and there makes but a ripple in the record, but when day after day on all sides we hear of this one and that one who but yesterday was in the fullness of apparent health and strength, and to-day is but "brother to the insensible clod," it raises a feeling of insecurity and uncertainty as to the stability of each and all about us. I thought, therefore, that a study of some of the general and special causes of sudden death in their application to the present, might be of interest to the Society. When that mysterious transformation comes, which we know as death, it has as its place of beginning, the head, the heart, or the lungs. Each form is distinguished by a different order and type of symptoms. Death may come by asthenia, its gradual approach, or by syncope or shock, which latter is the form we shall in this paper consider.

If the brain is the seat of the disorder, the patient is in a comatose condition, unconscious of what is impending, and unable to make any expression of what might be his most earnest wish. While in death proceeding from the heart or lungs, consciousness is unimpaired to the very instant of dissolution.

An instance of death from congestion of the lungs, (and this is a very common cause of sudden death,) is presented in the death of the Hon. Schuyler Colfax, who took a brisk walk of about a mile from one railroad depot to another in an atmosphere with a temperature of thirty degrees below zero, and reaching the warm air of the room, instantly perished. The previous cold followed by the great heat of the room causing such a blocking up of the pulmonary tissue as to inhibit the circulation at once. Had he gone into a room of a temperature but little higher than the outside air, no untoward results might have followed.

Aside from the rupture of blood-vessels in the brain, a subject to which I shall refer incidentally further on, the failure of the circulation from influences affecting the heart calls for the most consideration from us.

Of this form numerous cases have occurred in which the cause was so obscure that physicians, for want of a better explanation, have sent in the death certificate as "heart failure." The board of health consider this as too indefinite, and yet there are cases where nothing else can be said. Simply an inhibitory influence on the heart's action that induces paralysis and cessation of motion with perhaps no organic change or any morbid pathological condition that could be discovered being present. The effect of a sudden, violent emotion may contract, for the moment in a sudden spasm, the movements of the heart, and death ensues. The ingestion of very cold drinks when the system is in a heated condition may withdraw the blood from the heart, etc.; these are examples of this. A post-mortem examination would not necessarily show any pathological change. The heart is an irritable organ. On its irritability depends its muscular movements. Irritability is its normal condition.

And there are many causes that may lessen this vitality, bringing a state of weakness and lack of normal readiness of accommodation. A familiar instance of one of these causes is post-diphtheritic paralysis. Here the ptomaines evolved in the growth of the disease have enervated the heart—lessened its irritability through their inhibitory influence on the pneumogastric, or directly on the inherent vitality of the heart-muscle itself, and the vibrations of the organ are lessened in number and force or so quickened as to become imperceptible. In some instances I admit the heart shows marked organic change, but in others it is simply loss of nerve force. General weakness of the muscular system from long continued illness, such as typhoid fever or the drain of strength from waste of tissue in profuse suppuration, affect this normal tone and vigor of the heart-muscle so that with no organic disease of that organ the heart's action may become enfeebled to an extent that may endanger life. Old age, with the fatty degeneration that so often is present, lessens the normal irritability so that a sudden demand for increased action is followed by fatal results. And even when the heart-muscle is in ordinary condition it may be strained to an extent sufficient to cause death. In the Surgeon General's office, at Washington, are several reports of the effect of heart-strain in the cases of numbers of soldiers, due to faulty methods of dress and rapid and long continued evolutions in drill or march. Dr. Taylor says, in a report on the subject, "that as the soldier wears no suspenders, his trousers are gathered in tightly about the waist to hold them up and in position, and his coat buttoned up tightly as may be; over this comes the cartridge belt, filled with a certain amount of ammunition and drawn in an equally tight manner about the waist, and upon his shoulders he bears his well-filled haversack, knapsack, canteen, and lastly his gun. In this condition he is generally marched upon the ground at a quick pace, and after alignment he is brought to a stock-still rigidity of position to await inspection. It is now that one sees the initiatory signs of the effects of chest compression.

First there is a flush of the face, more especially in the cheeks, chin, ears and nose, and a deepened color of the lips, the veins of the neck become turgid and the respiratory movements limited to the upper portion of the thorax. Soon there is labored respiration, profuse sweating, then deathly pallor, staggering, and unless caught the man falls to the ground."

Now what is the explanation of this? Simply by compressing the lower ribs and upper abdomen the natural respiratory movements of the diaphragm are rendered nugatory, and the costal expansions prevented; the weight of the knapsack and its strappings holding the shoulders well back impedes the movements of the upper portion of the chest, and with this arrest of the respiratory action there is an impairment of the circulation of the blood through the lungs. As a consequence there is an accumulation in the right side of the heart and in the venous system, which is seen to extend back to the venous radicles and capillaries. Claude Bernard has suggested that under such circumstances the right side of the heart, especially the auricle and veins, may serve as a temporary reservoir, and dilatation go on to some extent without serious injury. The burden thrown upon the right ventricle however, in forcing the blood through the pulmonary system is too much for it, and it soon yields under the strain. At the same time there is a lessened amount of blood sent to the left ventricle, the effect of which is to diminish the ordinary supply sent through the coronary arteries for its own nourishment as well as the amount sent through the systemic circulation to the cerebro-spinal centres. Therefore both nerves and heart fail for want of support."

Balfour says, "We pay the penalty of our higher civilization in the greater influence of grief, and depressing emotions over the inhibitory centres." Now if to this we add the effect that fashion has had in faulty dressing the compression of the respiratory organs when our fair sisters are on dress parade we in the light of the above illustration can see a cause for some cases of syncope and heart

failure. Another case that should receive careful consideration is the effect that is produced by inconsiderate dosage of such drugs as affect the heart profoundly. A new class of remedies has suddenly sprung up. Drugs with strongly marked action, such as antipyrine, antifebrine, etc. Nervous headaches, painful neuralgias succumb to their potent force, and the sufferers hail the present relief without thought of future possible harm. Physicians give out prescriptions calling for these drugs for use as the patients deem requisite, and the laity purchase them freely and take them as they will. Under the observation of the careful physician, numerous cases of cardiac depression, induced by over-doses of these drugs have been seen and reported. It is doubtless the case when so general is the use of such a dangerous drug as antipyrine, that many cases of sudden death might be properly laid to this cause, and we should earnestly protest against its indiscriminate sale to the public, as a danger that is great and unavoidable while so used. In the hands of a physician, like chloroform, hydrocyanic acid and other dangerous drugs, these remedies form a valuable and comparatively safe relief from many painful and serious disorders, but unskillfully used, and unwatched, the risk is great.

Another cause for the frequency of fatal syncope I think can be definitely traced to the effects of the severe epidemic of *la grippe*, which passed over us last winter. Symptoms of this disease include a very remarkable effect on the nervous system in enlivening the strength of old neuralgies and allied nervous troubles, and in giving birth to many new neuralgies, and in the serious disturbances due to the very great depression of strength that followed in the train of the influenza. Many individuals have still weakness of the organs most affected by the disease. When the bowels were the point of the invasions, diarrhœas are readily induced. If the lungs were most involved, a weakness has remained that renders to the changes of weather many susceptible victims, and, if the nervous system was alone depressed a general exhaustion and

cardiac weakness are only too frequently met. In the active life of our bustling city, with the feverish haste and intense application of all to business or other pursuits of life, great demands are made on the nervous forces. Demands that when made to organizations weakened from such a potent cause find many to succumb to the strain. I have noticed in the cases of illness that I treat daily more of irregularities and faulty movements of the heart than ever before. It is more of an exception than a rule to find in the cases that I meet day after day a good, even, regular rythmical pulsation at the wrist, and there exists, I believe, a profound weakness and general depression of the tone of the heart as a legacy of the influenza in those cases where the disease had a strong hold. The weakness is not noticeable perhaps to the individual, but it is to the physician who is on the lookout for it, and is, I believe, the greatest of the factors inducing many of the class of cases we have been considering. Weakness of the heart is often present without exciting notice on the part of the patient. The readiness to lose breath on slight exertion being the most apparent symptom, and I have seen cases in which the heart pulsations were almost uncountable and barely preceptible at the wrist, in which the patient was unaware of anything beyond a sense of exhaustion that if not due to the heart might have been present without any injury of a permanent character. So there are these numerous varieties of *la grippe* that have the lack of vigor and energy, the exhaustion and weariness characteristic of the influenza still remaining, though the disease has been long numbered with the ills that were perhaps in a very mild degree or in a marked one, but in the vast majority of them the weakness of the heart muscle will be found to be specially marked.

In the effect upon the brain, *la grippe* has given some remarkable experiences; many became insane, some temporarily, others, it is to feared, permanently, and many died from the direct influence of brain disease, induced or aggravated by influenza. At the State institution for the

treatment of the insane at Westboro, Mass., the physician in charge reports some cases of insanity cured by *la grippe*, and as there has been an increase in deaths that have originated in the rupture of the blood vessels of the brain, it would give rise to a belief of the causative influence of *la grippe* in producing weakness of the muscular cords of the blood vessels and a greater readiness to rupture from that cause, and in the circulatory disturbances and the consequent lessening of the proper nutrition of the brain tissues, we have the explanation of the prolonged neuralgias as well as the more deeply seated lesions that have the tendency to lead to syncope.

Discussion.—Dr. W. P. MacCracken: In a recent talk with an old-school physician, he expressed his belief that fifty per cent of the cases of *la grippe* lost by his school were due to the indiscriminate use of antipyrine, and he took the same view just expressed by Dr. Gilman, that the sale and use of such harmful drugs should be restricted. I saw a case recently in which the patient, a woman, had taken forty grains within two hours. Venous stasis was marked in this case. No pulse at the wrist. With the stethoscope the heart sounds could barely be distinguished. The heart was making 135 pulsations per minute. The entire left side was black-and-blue. The only cause that I was able to discover was the use of the antipyrine.

Dr. R. Ludlam had enjoyed the reading of Dr. Gilman's paper, which was certainly very practical and suggestive. It would make a fitting sequel to the work that the Society had already done and published in the Clinique in connection with the recent epidemic.* The only criticism that he could offer was that no reference was made in the essay to rheumatism as a predisponent of fatal mischief in some of these cases. Even in milder cases of *la grippe* the rheumatoid type, as described by Jousset, had been troublesome and rebellious to treatment.

* See page 69 of this volume.

VOLUNTEER PAPERS.—1. HEAT-STROKE. BY DR. E. S. BAILEY.—The term heat-stroke rather than sun-stroke, is preferred because of the wider range of application, in cases where the illness is due to the effect of heat. Recently a hot wave has rested upon the western country, and many cases of heat-prostration have been reported, with a great death-rate.

It is a popular notion that a sun-stroke, or that prostration from heat, comes on very suddenly, almost without warning; that the victim has no way of escape, and that the danger is in proportion to the direct exposure. With rare exceptions, there are always some premonitory symptoms. Usually the patient complains of a parched throat and intense thirst and headache, that is of a congestive type. Dimness of vision, irritability of temper, a partial paralysis indicated by loss of motor power as in walking, lifting or in the coördinating movements of the hands or feet. The patient feels like one in a violent fever—in fact the symptoms are those of fever. These symptoms going unheeded and the exciting causes continuing, *viz.*, the continuous exposure to direct or to heat-radiating surfaces, the patient falls and becomes unconscious for a time, varying from a few hours to a few days. The changes in the system now noted are: The labored breathing, the embarrassed heart's action, the tardy circulation, the bloated face and the pallor or the purple color. The pathological changes now supposed to have taken place are: A paresis of the blood-vascular system, the veins especially being affected. The lungs are congested and the respiration is so impeded that carbonization of the blood is especially liable to take place; the patient being in danger of death from carbonic acid poisoning. A second, perhaps more critical condition, may ensue in that the large veins of the pia or dura mater are filled to distension with blood, the smaller veins not being so much distended. Sub-serous hæmorrhages may have taken place into the ventricles and softening of brain tissues is especially to be feared.

A second class of cases is of such as are overcome by heat-radiation, or a super-heated air in badly ventilated quarters, or from a temporary exposure to sun after the system has been subjected to a continued hot or stifling atmosphere. Such exposures may leave long and lasting results, but they are not as dangerous to life as the former ones. All of these premonitory symptoms should be heeded, and immediate attention given before more alarming ones ensue. A few illustrative cases may serve to suggest a line of treatment:

Case 1. That of a young man, an officer in the militia, who, while on parade during a hot sun, suddenly fell prone upon the pavement. He became unconscious, and although recovering from the severe symptoms in a couple of days was ill for several months before he could resume work. Although this happened to him five years ago, at every return of hot weather he now suffers with a relapse of the symptoms such as he had during that almost fatal day, but of much less severity. The treatment that relieves him, but does not seem to be curative, is the internal use of glonoine 30, and atropine or gelsemium for the excessive languor and stomach symptoms. The application of cold to the head is especially disagreeable and painful.

The cases of the second class are those most difficult to treat because the prostration from the heat has been almost always preceded by some conditions of ill health.

Case 2. A young man of nervous energy and great mental activity, who had been subjected to long mental strain and had passed two sleepless nights, walked a short distance in the mid-day sun. Faintness and dizziness came on suddenly, and he was observed to stagger and fall. In a few moments he was carried to his home unconscious, his temperature being 104. Nausea and vomiting were soon followed by purging, great pallor and extreme prostration and indeed, all of the symptoms of collapse. Veratrum viride 3, was administered every five minutes: a stimulant of brandy subcutaneously; a cold pack applied to the head; hot mustard water to the extremities and flannel bandages wet in hot water wrapped about the limbs. Relief followed in a few hours, but the patient was prostrated for several days.

Case 3. Liveryman. While out exercising a trotting-horse in the sun and wearing a heavy black hat (something unusual for him), was seen to fall from the sulky. The exposure to the sun had been of short duration. On reaching him he was found to be unconscious. The pupils were widely dilated, and the face livid and swollen from local congestion. Being assisted to his home he soon regained consciousness, but became so insanely violent that it required three persons to restrain him. His ravings soon took on the form of screaming, because of the pain in his head. The cold compresses he would not tolerate. Glonoine 3, and hyoscyamus 3, were frequently repeated in alternation. In six hours he insisted upon going to work again and though unable to walk he reached the front door by crawling on his hands and knees, and the sidewalk by sliding down the stairs. A friend assisted him in walking, and although he kept up, the strange sensations in his head did not disappear until after the second night's sleep.

It has been my good fortune not to have had a case of the first class recently, but from the experience of former years I should recommend the following line of treatment in severe cases: Place the patient in the coolest place where air is stirring, in the immediate vicinity of the accident; remove all clothing and envelop the trunk of the body in a sheet that can be kept sprinkled with cold water, preferably not iced. The extremities should be wrapped in a blanket, and to the head a coil of rubber tubing arranged in a skull-cap of flannel, and cold water be made to pass through it in a continuous stream. This can be continued as long as the congestive symptoms are unyielding. If the cerebral symptoms point to serous effusion, or the pulmonary cardiac embarrassment continues, I should unhesitatingly cord the arm and practice venesection. One point of great importance: During the premonitory symptoms I unhesitatingly recommend the frequent use of aconite in a low potency, and continue its use until the vaso-motor system is fully under its influence.

DISCUSSION.—Dr. J. E. GILMAN: I was called to see a child, æt. six months yesterday morning. Up to that time it had appeared perfectly well, and the family did not know

that anything was the matter with it until it was unable to swallow. The child was comatose when I arrived, and died in a few minutes. Its temperature was 105°, the head hot and the body cool. This is the only case that I have had so far this year.

DR. LUDLAM: Had the child been especially exposed to the heat?

DR. GILMAN: Only to that of the room in which it lived —a top flat in an apartment building.

DR. R. M. BARROWS: Dr. Johnson in his work advises the application of hot water to the head and limbs. Have any of our members tried this?

DR. GILMAN: In the earlier stages this would be of great value. Any one who has taken a cold bath on a warm day will have noticed that as soon as the immediate effects had passed off they were warmer than before. A child that is given a warm bath before retiring will be cool and sleep well all night.

DR. MACCRACKEN: I saw one case of sunstroke to-day. I was hailed by some men at the side of the road, and on going up to them found that they were working over another who had been overcome by the heat. I found the patient comatose, the lips were livid, the hands and the arms to the elbows were mottled. They were applying whisky and ice to the back of the neck and to the head, and had given him whisky internally. The heart's action was very feeble. I ordered the cool applications continued and also to be applied to the chest. Belladonna and glonoine were given internally. He improved under this, but the patrol-wagon arriving at this time he was taken to the hospital, and I am unable to give the ultimate result.

DR. R. M. BARROWS: I had a case of unusual interest two or three years ago. The patient had been in the business part of the city most of the day and indulged liberally in cold drinks and ice-cream. He was brought home unconscious. Ice was applied to the head and synapisms to the soles and calves of the legs. He was insensible for twenty-four hours. The pulse was very feeble. Digitalis,

etc., were used to increase the heart's action. He came out all right eventually.

Dr. Hempel, in his translation of Jahr, advises rubbing the body with ice, and the internal use of glonoine. Jahr formerly recommended bryonia and gelsemium in these cases, but later put glonoine first.

DR. W. H. BURT: Because of fatigue and the excessive heat it required a great struggle before I decided to come here to-night; but can now say that I am delighted that I did come. I have had no cases of sunstroke, so far, this year, although I have seen many in times past. Bryonia, gelsemium, belladonna and glonoine have all done good service in my hands. Glonoine I have frequently found useful.

THE PRESIDENT: How low do you use glonoine?

DR. BURT: Pretty low; as low as the second decimal. I have used all the remedies mentioned, but think that bryonia has given me the best satisfaction.

DR. MACCRACKEN: What have you used locally?

DR. BURT: I have always used cold applications.

DR. BARROWS: In the Boston Hospital they used to turn the hose on these patients.

DR. E. S. BAILEY: I fully believe that, if we could get these cases early enough, aconite would be the best remedy. Its sphere of action is on the vaso-motor nerves, and exactly meets these conditions. It is not cumulative, and its time of action being short, the dose can be repeated every ten or twenty minutes. I should use it in the second fluid potency and continue until its physiological effect was produced.

Dr. Barrows' case was successful for two reasons. (1.) The long continued use of stimulants prevented heart-failure, and (2) the congestion was not sufficient to cause tissue disintegration.

The first symptoms of these attacks call for aconite. Later gelsemium is better indicated. I have never tried bryonia, but from its pathogenesis it should be useful.

Dr. W. A. Dunn: The symptoms depend somewhat on the part of the brain most affected. In the case referred to the lesion was of the vaso-motors of the anterior portion of the brain. So, while there was little pain there was an abundance of mental symptoms. In fatal cases the lesion is situated on or near the pneumogastric or other nerves controling the heart, etc. The pathological condition is undoubtedly a paralysis of the vaso-motors first and afterwards a destruction of cells.

Dr. H. P. Holmes: The only case that I have seen this year was that of a horse only a few hours ago.

I remember hearing Dr. Laning say, when I was in college, that he considered the proper treatment to be the application of heat to the chest and cold to the head. My general remedy, especially where the patient has been indulging too liberally in cold water, is bryonia. When the patient is subject to these attacks from year to year glonoine is especially valuable. I remember that when I was a boy I had a light stroke. The most prominent symptom was a roaring in the carotid pulse. I have heard others mention the same thing.

Dr. R. Ludlam said he would submit that Dr. Bailey's paper and the drift of the discussion, as well as the general experience of the profession showed that in treating cases of heat-stroke we had to do with several kinds of apoplexy arising from a single cause. Naturally enough a stereotype form of treatment would not be suited to, and could not be successful in all of them. Too much cold is certainly harmful.

There was one point in the care of these cases that had not been mentioned, and which he thought should be emphasized, and that was the risk of injury from lifting and carrying and carting these patients about too soon after they were taken ill. No doubt many persons have been killed in this way, just as they were during the cholera epidemics.

2. A VERY RARE EXAMPLE OF ABDOMINAL TUMOR IN A MALE SUBJECT. REPORTED BY ROBERT CHISHOLM BAIN, M. D. The following case recently came under my care as surgeon to the Cook County Hospital in this city, and being of rare interest to me I have taken the liberty of presuming it might interest some who are here this evening.

Case. The patient, a Frenchman, 45 years of age, was admitted to the Cook County Hospital May 2d, 1890. At the time of his admission he was quite weak and complained of a swelling in the left iliac region. The examining clerk decided this to be a surgical case, and fortunately for me, if not for the patient, assigned him to the Homœopathic department.

I first saw this patient on the afternoon of May 5, at which time he was in bed, although he had been up and around the ward a short time previous to my seeing him. His history is as follows: Six months ago he contracted syphilis, which was followed by enlargement of the inguinal glands. Like many of his countrymen, he was an habitual wine drinker. He had had chronic constipation for a number of months, but for the past few days his bowels had moved very freely. About two weeks previous to his coming to the hospital he first noticed an enlargement in the left iliac region. He did not know how long it had been there, nor did he know whether its growth had been gradual or rapid. He did not think it had increased materially in size since he first noticed it. The only pains of which he complained were like colic, and were present only after walking or exerting himself physically, and they had been noticed only since his discovery of the tumor in the left side. Examination of the patient showed him to be emaciated and jaundiced, though not markedly so. The breath was offensive, the tongue coated with a dirty, grey coating, and the teeth carious. The pulse was 88, regular, but not very strong. The temperature was 99 1-5°. He had had no chills. The inguinal glands were swollen, tense and hard, and several of them had suppurated and discharged spontaneously. Upon manipulation of the abdomen an oblong, non-fluctating, non-pulsating tumor, which was smooth and slightly yielding to the touch, was found to occupy a portion of the left side of the hypogastric region, most of the left iliac and the lower portion of the left lumbar regions. Over the tumor the part was flat and slightly painful on percussion and manipulation. The pain ex-

tended from the tumor around the abdomen to the lumbo-dorsal region of the back. Further examination revealed a flatness of the back in the region mentioned and a loss of prominence of the spines of the vertebræ at that point. Pressure over the first two or three lumbar vertebræ caused pain, but it was not sufficiently marked to cause me to attach any especial significance to it. Percussion over the abdomen showed it to be slightly tympanitic, which was probably due to the crowding of the intestines toward the right side by the tumor. There was slight pain when percussing over the liver. No urinary symptoms were present. There was no heat or discoloration of the integument over the tumor.

The correct diagnosis of this case was not to me at least, an easy thing to make. I attributed the colicky pains, the coated tongue, the offensive breath, etc., to an attack of jaundice; but the nature and presence of the tumor were not so easily explained. The condition of the bowels, the lack of a sense of fullness and weight in them and of a desire for stool, and spasm of the sphincter ani, ruled out fæcal impaction. The position of the tumor, the absence of urinary symptoms, and of fluctuation, did the same for hydronephrosis. The fact that the tumor was entirely above Poupart's ligament, was non-fluctuating and had no history of pain beyond that previously mentioned, inclined me to believe that it was not a psoas abscess. The only remaining causes which I could assign for the tumor were hæmatocele, iliac abscess, and partially softened induration of the abdominal wall, but I must admit that I was decidedly uncertain which to call it.

As for an abscess of the abdominal parietes, I could find no history of traumatism, no elevation of temperature, or pain, except of a slight nature on manipulation. The rarity of hæmotocele in this region, and my inability to find a cause for the necessary hæmorrhage to produce such a tumor; and the lack of fluctuation of an iliac abscess tended still further to increase my indecision with reference to its exact nature.

As I did not have the time to continue the examination further, and did not think there was need of any great haste in its completion, I requested Dr. Smith, the senior house surgeon, to aspirate the tumor and see if any of its contents could be withdrawn, and thus aid us in our diagnosis. But owing to the amount of work the doctor had on hand for that night, he put off aspirating until the following morning.

May 6. About 9 o'clock the nurse hurriedly called one of the doctors to see the patient whom we had partially examined the afternoon before. Dr. Bennett, the junior house surgeon, answered the call and found the patient in a state of collapse. The pulse was almost imperceptible, the eyes fixed, breathing very difficult, and he was apparently unconscious of things around him. By catheterization three ounces of urine were obtained. Examination showed the tumor in the left side to have increased to twice its size of the night before. Whiskey, digitalis and glonoine were given hypodermically but to no avail, as the patient died very soon after the doctor reached his bed. However, before the patient's death Dr. B. aspirated the tumor and drew off a small quantity of a thick, grumous fluid, containing what appeared to be pus mixed with blood. The nature of the tumor was now more clear, but the source of the hæmorrhage was still a mystery. The privilege of a post-mortem examination was then requested of the patient's brother, and after considerable delay was granted.

May 7, the day following the patient's death, an autopsy was made by Dr. McKinney, the senior house physician, the resident surgeons not being allowed to be present at any post-mortem examinations for fear of infecting the cases for whom they have to care. That examination showed the gall bladder to be full of gall stones. The kidneys were of a dirty gray color throughout. The posterior surface of the abdominal aorta was found to be adhered to the anterior surfaces of the bodies of the first and second lumbar vertebræ. At the lower portion of the adherent part of the aorta an opening large enough to admit the passage of the doctor's finger into the cavity of the vessel, was found. The adhesion of that part of the artery to the vertebræ had evidently given way, causing the fatal hæmorrhage.

From this opening in the artery a large sub-peritoneal extravasation of blood into the left iliac fossa had taken place. This had formed the tumor which we had found in the left side of the abdomen. Upon dissecting the aorta from the vertebræ, to which it was attached, it was found that the entire central portion of the posterior wall of the artery where it was attached to the spinal column had become absorbed; also the anterior surfaces of the bodies of the two vertebræ mentioned had become absorbed, about a quarter of an inch of their thickness being gone; they were also very smooth. Induration and thickening of the muscles over the spines of the affected vertebræ were

found, which accounted for the flatness of the back and the loss of prominence of the vertebræ at that part of the spinal column. The cause of the adhesion of the aorta to the spinal column was probably due to an aneurism, which in its turn was probably due to his attack of syphilis or to a degeneration of the coats of the artery, followed by ulceration due to alcoholism. As the patient could give no history that would indicate a sudden or extensive loss of blood, the part of the tumor first noticed was probably due to passive hæmorrhage, which had continued for some time before the patient first observed the tumor, and which continued until the final and fatal hæmorrhage occurred.

The history given by the patient does not lead us to suppose that a clot formed in the opening in the aorta through which the first hæmorrhage took place, as he does not appear to have been at any time sufficiently depleted from loss of blood to have caused the action of the heart to become so slow and weak that a clot might have formed and thus arrested the hæmorrhage. I neglected to mention that an aneurismal *bruit* could not be detected on auscultation. This was probably due to the fact that the anterior surfaces of the bodies of the vertebræ to which the vessel was attached, formed the posterior wall in such a manner that at the time he entered the hospital the cavity of the aorta was but very slightly greater than that of the normal aorta at that point. Had the case been examined before the attachment of the aorta to the spinal column an aneurismal *bruit* would no doubt have been detected. The specimen of the aorta as it was dissected from the spinal column, shows but a very slight increase in the size of its calibre.

3. Two peculiar cases. By H. P. Holmes, M. D., of Sycamore, Ill.—I wish to present to this Society a report of two cases that are of interest to me and which seem so unusual that I hope they will prove of interest to the profession. Both of them differ enough from the usual line of work to entitle them to notice, and I wish to place them on record. The first is a case of membranous dysmenorrhœa and the second one of prolapse of the anterior vaginal wall.

Case 1. Membranous Dysmenorrhœa.—Miss X., aged 23, a very dark brunette, medium size and well developed, came to me one month ago for the treatment of a compli

cation of troubles of which membranous dysmenorrhœa is one of the most prominent, especially as far as personal suffering is concerned. During the present week her first menstrual period has occurred, while under my treatment, and I have secured the membranous cast for your inspection.

The membrane, as you see, came away entire and represents the shape and size of the uterine cavity. It was placed in an alcoholic solution which shriveled it somewhat, but it was practically four inches long and three broad, and evidently reached from the fundus uteri to the external os. It is much larger than the normal virgin uterus and bears out the general opinion that in cases of membranous dysmenorrhœa we usually find the uterus enlarged. This membrane does not have the typical appearance of the casts usually expelled in similar cases. The weight of authority states that they should have the appearance of a placenta: that is, with one side comparatively smooth and the other of the well-known villous appearance. This membrane is perfectly smooth on both sides, is very thin and of a regular thickness throughout, and has much the appearance of parchment or more nearly that of the lining membrane of an egg. Such membranes are exfoliated from mucous surfaces where strong solutions of alum are used as in the notorious orange blossom and other like preparations. The patient has never used any of these preparations, neither is there a history of a miscarriage in the beginning of the malady. In this cast I was unable to find any openings denoting the sites of the orifices of the Fallopian tubes. The body of the cast is smooth and regular in shape, while the portion that came from the cervix is neatly folded in accordion pleats. These pleats run longitudinally to the direction of the cervix. On each side of the cervical portion is a fold or depression running perpendicularly the length of the cervix and shows the position of a sharply defined rugar on each lateral portion of the cervix.

A history of the patient's malady does not bring out a suppressed skin disease as the cause of her membranous dysmenorrhœa. If there was anything of the kind in her childhood she has never heard of it. Her early menstruations were always painful, but no casts were noticed. At the age of sixteen years she suffered a long illness of what was diagnosed enteritis, followed by typhoid pneumonia and typhoid fever. About two and a half years ago the

dysmenorrhœa began to take on its present habit of throwing off complete casts similar to the one here presented. These have varied somewhat in thickness, many of them being thicker than this specimen. The patient does not remember of seeing any that would be typical of the placenta-like appearance of such membranes. The flow is always profuse and is attended with great pain until the discharge of the membrane, which must often be pulled away.

At the time of first seeing the patient the inflammatory remains could be traced in the indurated portions of the peritoneal membranes surrounding the uterus, which was quite solidly held by these adhesions. From this condition we see that her case was one of pelvic peritonitis and was probably that instead of enteritis. There is retroversion in the second degree and slight prolapse. The cervix is very much enlarged and the external os is fissured so that it bears the appearance of a stellate laceration. In this place I wish to call attention to a statement made at the recent meeting of the American Institute of Homœopathy, that "where we find a hyperplastic cervix with fissure of the os in a woman who has never borne children the case is undoubtedly of a cancerous nature and demands immediate attention."

There are some unusual features about this case which make it different from those heretofore reported. First, there is no history of a skin disease as in many similar cases where the suppression of the eruption has led to the appearance of the membraneous dysmenorrhœa. Second, the membrane is not the typical one of this malady as it is the smooth, parchment-like formation instead of the villous, placental appearance. Third, the cervical hyperplasia with stellate fissure of the external os predicating it to be of a cancerous nature places the case among the most serious ones. Fourth, there is no likelihood of there ever having been an interrupted pregnancy as to the origin of the habit of this monthly denidation.

As to the treatment of this case I can give few facts at present. My attention will be given largely to the search for the "peculiar, prominent, uncommon symptoms" which go to make up the indications for the true similia. If I can find, through the patient's mother, a history of a suppressed skin disease, I shall treat the case from that basis.

Case 2. Prolapse of the Anterior Vaginal Wall.—Miss Y., aged 55, several years past the menopause, came, last

December, to consult me with reference to what she feared was a cancer appearing in the vagina. A few weeks before she had lifted a heavy tub and at the time felt something give way and the next morning noticed the protrusion of a tumor from the vagina. Her great and only fear was a cancer and this so tortured her that she hardly ate or slept for several days and spent much of her time in crying.

A lady friend who has the fashionable habit of our suburban towns so discouraging to a would-be local specialist, persuaded her to visit the late Dr. Byford, of Chicago. After what seemed to be a thorough and conscientious examination of the case, the patient and friend were assured that there was not the slightest thing the matter with the patient and that she might go home and never fear a cancer or any other difficulty as far as the present conditions were concerned.

But this advise did not quiet the patient's apprehensions nor stop her worry, for, feeling certain there was something abnormal, the negative opinion, though from such high authority, only the more convinced her there was something very obscure, though very definite, the matter with her.

More to ease the patient's mind than with the hope of finding any mal-condition, her friend came to me and requested that I make an examination and do as much as I could to convince the patient that her fears were groundless. I made the examination on the 12th of December in the presence of the same friend who had been present at the examination made by Dr. B. On direct examination there appeared between the labiae a tumor the size of a hen's egg. It was covered with a mucous membrane, was perfectly smooth and puffy in consistence. Slight pressure replaced the tumor, and an effort on the part of the patient, as a strain or a cough, brought it down again. On replacing the tumor with the finger it entirely disappeared and could not be felt or located, which led me to say at once it was a prolapse of the vaginal wall. Its position seemed to be anterior, but this was not accepted without verification. I passed the speculum and inserted a uterine sound. The speculum was then withdrawn, leaving the sound in the uterus. The patient was told to bear down or strain and as she did so the tumor immediately made its appearance anterior to the sound. This was twice tried in order to make no mistake, and all of the manipulations were made in the presence of the friend who saw and understood each

feature. That it was not a cystocele was also proved by the use of the metallic catheter in the bladder.

The uterus was found in the second degree of retroversion, was replaced with a Ludlam repositor and held with an Albert Smith retroversion pessary. The tumor has not since appeared and the patient has no more dread of cancer. A happier mortal over her change of condition it would be hard to find.

This case is unique. In the Cyclopedia of Obstetrics and Gynæcology, Vol. vii., page 249, I find: "Anterior vaginal hernia is extremely rare, and only a single observation, which is unfortunately not quite accurate, has been reported." Again in Vol. x., page 272 of the same work, I find: "The protrusion of the anterior wall (descensus or prolapsus vagin. anterior) may be partial, and originate now from the lower and now from the upper segment of the vagina; or, it may be complete. In both the latter cases it is regularly accompanied by sinking of the collum uteri." In the case already cited the protrusion came from the upper segment of the vagina.

The most plausible explanation of the oversight of the noted specialist, is that in making a digital examination without first inspecting the parts, he unwittingly replaced the tumor and then had nothing to lead him to an investigation of the case in hand. I wish this case to go on record as a genuine case of prolapse of the anterior vaginal wall.

Reference of specimen for microscopical examination.—The specimen obtained from Case 1 was by vote of the Society referred to Dr. H. N. Lyon for a careful microscopical examination.

4. Diagnosis, its use and abuse.—By Dr. C. E. Laning. The diagnosis of a case, if properly made, is of the utmost importance to the physician, and patient too, for the matter of that. It is only an imperfect diagnosis that is either negatively or positively harmful. The giving to a certain group of symptoms the name of a disease and then treating all cases so named alike, is a flagrant abuse of diagnosis. In making a correct diagnosis—one that the therapeutist can work by—it is necessary to take into consideration more closely than is generally done, the significance of the individual symptoms entering into a given case. We should let each

symptom be equivalent to a letter of the alphabet, and then be familiar with the word they represent when presented to us in a certain combination. To diagnose a case as one of headache, constipation, etc., is to make no diagnosis at all, and he who attempts to prescribe upon such a basis is sure to be wrong in the selection of his remedy, or at least has only a chance of being correct, and in this kind of prescribing there is no certainty, no science.

When a patient presents himself for treatment saying, I have headache or neuralgia, a great many physicians accept his diagnosis and at once begin to treat him for headache or neuralgia. If the patient complains of frequent desire to void the urine, the diagnosis of "frequent urination," is not made, for the veriest tyro would recognize this as but a symptom dependent upon some condition back of it. The headache, or nerve pain, deserves no more dignity diagnostically considered, than does the frequent urination, although more is usually accorded them. Almost all of the evidences we have of disease is what we detect at the periphery. We cannot see the changes which take place in the anterior spinal cornua in cases of progressive muscular atrophy, nor can we by any means at our command, see, hear or feel the changes which occur in the posterior columns in locomotor ataxia. We can only recognize their presence by the proper interpretation of the peripheral symptoms. If, however, we can interpret these correctly, how accurately can we arrive at the nature and location of the lesion upon which these peripheral symptoms depend. Any physician of experience not wedded to some pet theory or exclusive dogma, knows that he is better able to prescribe for his patient accurately and successfully, if he knows whether the pains in the lower limbs are rheumatic or neuralgic, whether due to simple functional derangement of the nerve fibre conducting the pain, or to functional disturbance of the nerve centres giving origin to the nerve, or to organic change in the posterior spinal column, or to cerebral or spinal tumor.

We are altogether too prone to stop at some peripheral symptom, or at most, take a few into consideration and think we have read the whole page down instead of having only read a word or two.

It is often as if one who could see type of only a certain size, vowed that there was no printed matter on a given page, except that which he had read, not allowing for the fact that much of importance might be in type too small for his discernment. On the same principle we often overlook some of the symptoms (which represent letters) and hence cannot make those observed spell anything, or else by noting only the first or most prominent ones make them to spell "*and*," whereas, if all the symptoms had been properly grouped, they would have spelled "Andrew;" or, instead of spelling gastric or cardiac lesion, they would have plainly read spinal or cerebral disease.

A lady came from a great distance some time ago to consult me regarding a complication of diseases for which she had been treated by many doctors. Her difficulty had been variously named: neuralgia, chronic gastritis, ovarian and uterine disease, heart disease, etc., but, although she had been treated for all these diseases by specialists, she had received no benefit from any of them. Now, in this case, each physician had seen only the letters his eyes were focused for. Hence, to one the combination reads uterine, to another cardiac, etc. A careful scrutiny of the entire group of symptoms present, giving each symptom its proper relation to each other symptom, made the case read, spinal ischæmia, and in these two words were found all of the letters or symptoms of the case.

An hypothesis can only be considered correct when it accounts for all the phenomena observed in the subject being investigated. Indeed, more than this is required, for it must be shown that no other hypothesis could equally well account for the conditions present.

In the case cited, some considered whatever of heart trouble they recognized, as representing a uterine reflex, others were sure that the entire trouble was gastric and that

all other symptoms were secondary. The whole difficulty was in the fact that none of them had weighed the symptoms separately so as to know the value of each, and neither had they given due consideration to the order in which they had developed, nor to the conditions under which individual symptoms were aggravated or ameliorated. Their eyes had been trained to see only a certain object; thus to one the womb was magnified, so to speak, and seemed the most important organ in the body, to another the stomach, and so forth.

In the case just referred to, treatment directed to the seat of the difficulty, calculated to remove the ischæmic condition, soon caused marked relief of all the other symptoms or diseases, as they had been previously considered.

I realize that this paper is perhaps not in the strictest sense clinical, but it is based upon deductions made from clinical experience, and I think that there are a great many things which need clearing up in order that the law of similars may be more frequently made use of in a successful and scientific manner, and the only way this can be done is by throwing the light of clinical experience upon the obscure points.

There is no doubt that *similia similibus curenter* formulates a law. There is equal certainty that there is a law of gravitation, but there are few of us familiar enough with the working or application of this law, to, as Keppler did, locate a previously unknown world. We cannot discover a new planet through a perfect knowledge of the law of similars, but we may do what would be of vastly greater benefit to mankind, viz., cure some disease or diseases which have hitherto resisted all known therapeutic methods.

There can be no question in the mind of any unprejudiced physician, that in a given case, an early, correct diagnosis is of the utmost importance. It not only enables him to make, at least, an approximately accurate prognosis, but positively enables him to the more certainly select the curative remedy. The very fact that those who are opposed

to diagnosis claim that by diagnosing a case incorrectly the physician is misled in his treatment, is one of the strongest arguments they could bring forward to show how imperative is diagnostic skill.

The abuse or improper use of any good thing will always produce harm. Diametrically opposite methods in the use of any instrument cannot fail to bring about diametrically opposite results. There is just this difference between the results obtained in practice by the skillful and the unskillful diagnostician.

I therefore repeat what I have often said, all things being equal, the best diagnostician is the best homœopath, and the best and most scientific prescriber.

5. ABORTION WITH THE FŒTUS IN PROCESS OF RESORPTION. —BY DR. E. C. READ, of Blue Island, Ill.— *Case.* Mrs. H., is a German, aged about 26 years, mother of one child, which is three years old. Not knowing she was pregnant she did a large washing, and carried the water out of the house in the tubs to empty it. During the latter part of the night she was attacked with severe pain in her back, hips and abdomen. She thought she had taken cold and it would soon wear off, which it did, and she went to sleep again. In the morning she awoke with slight pain and as she was flowing some and feeling wretchedly, she decided to remain in bed. But as her lord and master wanted his breakfast and declared it was only laziness on her part, she got up and afterwards suffered for it. During the morning she went next door to her mother's and was taken with fainting and violent pain in the womb, and had to be carried home. I saw her about 1 o'clock that day, and after learning the history of the case made an examination and found lying in the vagina, completely outside the uterine cavity, an oval mass of rather firm and compact fibrinated tissue. The os uteri was dilated and a large clot of blood protruded from it which I at first took for the placenta, supposing that I had nothing but a fœtus, but a close examination convinced me that there was no afterbirth outside of the tumor which I had extracted from the vagina. Before removing this clot I put into a glass half filled with water a teaspoon two-thirds filled with the fluid extract of ergot and gave her teaspoonful doses of this at intervals of ten minutes, and had the satisfaction of seeing the womb con-

tract by the time I had finished cleansing it of all the débris. After the womb was thoroughly contracted I poured out all but about two tablespoonfuls of the ergot and filled the glass again half full of water. I gave her this in alternation with arnica 1, every half hour, as I believed that it originated through mechanical interference. She made an excellent recovery.

After making the woman comfortable I turned my attention to the mass which had been extruded. Its dimensions were about three by four inches; it was smooth and regular in outline and covered with a thin, delicate glossy tissue, which to the naked eye closely resembled mucous membrane. I cut longitudinally into the tumor and found in the center a perfectly-formed fœtus in an advanced stage of decomposition although intact, but wherever I punctured it, thin pus gushed out. I believe that had the tumor remained in the uterine cavity eventually the fœtus would have been absorbed, and how long it had existed I had no means of determining.

Guernsey starts out with the proposition that "Moles and hydatids are the various shapeless bodies which are occasionally discharged from the vagina. These may consist of masses of squamous epithelium from the vagina itself or the membranous product which is expelled in some cases of dysmenorrhœa, or of fibrinous collections from the cavity of the uterus. These constitute three varieties of what may be termed false or spurious moles, as occurring in the unimpregnated female." Now it seems to me that these constitute false or spurious terms instead of false or spurious moles, and I don't see why authors classify them as they do. The literal meaning of hydatids is a tumor filled with an aqueous solution containing the microbe tænia echinococcus, and the membranes exfoliated in some cases of dysmenorrhœa are casts, nothing more nor less.

Then Guernsey goes on to say that "the true or genuine moles are all the result of impregnation and their different varieties may be arranged under three classes, blighted ova, fleshy moles, and vesicular moles or hydatids." The first two propositions we accept, but the third we are obliged to reject, for I don't believe that a true hydatid is the result of impregnation, but simply a formation of its own filled with fluid and containing tænia echinococcus, and may be found in any organ in the body, but more especially the liver.

6. Salicylate of soda in a form of periosteal rheumatism. By Dr. Thos. Gillespie, of Kenosha, Wis.—*Case. Z.*, a man aged 47, who never had gonorrhœa or syphilis in any form, was taken in the spring of 1884 with rheumatic pains in the fingers and hands, creeping slowly to the elbows. Thence it was suddenly translated to the spine of the tibia of both legs. The pain was intense and agonizing, but was regularly periodical, coming on at 6 p. m. and continuing without abatement until 6 a. m. While it did not entirely disappear in the interval the relief was relatively very great. There was no absolute intermission and no perspiration at the close of the paroxysm. The bodily functions were not seriously disturbed. He took all kinds of remedies, including china, high and low, arsenicum, mezereum, and other periodical remedies, with only very slight and temporary relief. Quinine did no good at all. Local applications had no beneficial effect. Very hot water and anodyne lotions did no real good. The suffering was extreme and almost unbearable.

When this state of things had continued for four weeks I gave him a preparation of the salicylate of soda triturated with the sugar of milk in equal parts. Of this three grains were taken every two hours. The third dose gave almost absolute relief, and a few repetitions of the same entirely disposed of the trouble. There was no crisis, and no further translation of the disease. Moreover, for the last six years any apparent return of the symptoms has been wiped out by a dose or two of the same remedy.

Since that time I have relieved several similar, although less severe cases of periosteal rheumatism which had nothing in them of a specific character. In such cases my habit has been to give this remedy in the first decimal trituration, repeating it every two hours until the worst symptoms have passed off, then giving it less often. I have never seen any injurious consequences to follow its employment either on the side of the heart or of any other organ.

7. CATAMENIAL IRITIS.—BY DR. A. TROUSSEAU.—Translated by Dr. Ludlam, Jr.* After referring to the interesting and complete work of Cohn (Wiesbaden, 1890) on the importance of secondary uterine affections, Dr. Trousseau reports the following remarkable

Case. Madeleine E., aged 35, had been in good health until the end of 1887, when she had an attack of acute articular rheumatism, which confined her to the house for about eight or nine months. She presents no signs of any complication, and the heart is not involved. She has always had her courses regularly, and without any mishap, despite an endometritis which gave rise to a catarrhal leucorrhœa.

Three years ago, never having previously suffered with her eyes, she was seized with a violent but temporary iritis of the left eye which came two or three days before the period, and disappeared some five or six days after the cessation of the flow. At this time the diagnosis of iridochoroiditis with hypopion, was made by a Parisian oculist, who prescribed atropine and the salicylate of soda, supposing, undoubtedly, that there was a rheumatic diathesis.

From this time for twenty-eight months without exception, she was attacked with the same trouble, sometimes a little before, almost always during, more rarely after the period. In the two cases in which it followed the menses the eye was simply red, without the small white spot (hypopion), and the redness disappeared after forty-eight hours with two applications of the atropine.

Although haunted by the return of these crises, which were subsiding somewhat, they suddenly ceased, and for an obvious reason. I first saw this patient June 13, 1889. The left eye was red, injected, almost dry, the iris slightly changed in color and downy; the pupil, half-dilated by atropine, was irregular, the crystalline lens looked as if it had been pricked, and there was a trace of torn adhesions; in the vitreous body which was slightly clouded, there were some floating flocculi. The lower fifth of the anterior chamber was the seat of a very liquid hypopion, which was displaced with the slightest movement of the head. There was neither pain nor photophobia, but torpidity had always been one of the chief characters of the affection.

* *Archives de Tocologie, des Maladies des Femmes, etc.*, for June 20, 1890, p. 345.

When questioned, the patient gave me the history which I have just cited, and seemed very much disheartened. In fact she had believed herself entirely rid of her disease, which had not reappeared for eight months, at which time she had become pregnant and the menses were suppressed. But the old eye trouble returned with its usual symptoms exactly at the date when she would have expected the menses, if the ovum had not been impregnated. I could only order the atropine, and five days later the eye had resumed its normal aspect. The hypopion had disappeared.

The month following she was delivered at term, and was submitted by the accoucheur to a thorough local disinfection. Her lying-in was normal, her first menses came and went without any accompanying trouble; but one day before the appearance of the second period, the iritis returned with the same hypopion. This time I punctured the cornea and examined the liquid, which had the morphological and bacteriological characters of ordinary pus. On testing this pus by inoculation it proved to have no septic character.

On the fourth day the eye presented its natural aspect. I persuaded the patient to follow a preventive treatment, and prescribed light purgatives—naphthol and the sulphate of quinia internally—with carbolized vaginal injections. She would not consent to consult a gynæcologist who would have taken the proper care of the endometritis.

Two days before the next period she had a slight congestion of the eye, which quickly disappeared without treatment. But the fourth period since her delivery brought the same old symptoms which have since returned every month, except when she has taken the salicylate of soda as an anti-rheumatic remedy instead of the antiseptic treatment, and which was more efficacious than the latter. I have not seen the patient during the last month, and she may have gone to another physician. It is worthy of note that the lachrymo-nasal passages, the eye-lids, the conjuctiva and the cornea were in a perfectly healthy state.

Here then was an internal affection connected with menstruation in which the relations of cause and effect are established in an extraordinary manner. I insist upon this curious and characteristic fact: the eye-disease disappeared with the arrest of the menses at the beginning of pregnancy. The iritis returned during gestation, but tow-

ard the end of that period and at a date in the month when the courses were due. Evidently the irido-choroiditis was of an infectious origin. The hypopion proves it. It is rational to locate the point of departure for the infection in the uterus, and this explains the endometritis. But for the inveterate resistance of the patient I would have made some bacteriological experiments with the catarrhal discharge, and would have discovered its precise character at the menstrual period. Was the appearance of the eye lesions regulated by the changes in the nature of the discharge, or simply by the particular condition of the local and general circulation during the menses? Did the epithelial and vascular phenomena which occurred at that time in the uterus favor the absorption of septic products and thus give rise to a moderate sepsis?

Cohn has reported a case of serious purulent irido-choroiditis occurring in the puerperal state which in some respects is similar to my own case. One may object to my theory of the integrity of the eye during the days that followed delivery, and when the infection had fair play, but the facts confirm my hypothesis, for the patient was subjected to strong and thorough antiseptic irrigations.

The sudden appearance of the eye symptoms was favored by the rheumatic condition of the patient. It was just before her attack of articular rheumatism that she had her first spell of iritis, in which the latent diathesis showed itself very decidedly. And it is this diathesis which explains why these ocular structures have been the special seat for the development of this infectious mischief. Is not this a weak point with rheumatic subjects?

Hospital Notes.

CLINIC FOR THE NOSE AND THROAT.

SERVICE OF PROF. W. A. DUNN.

FUNCTIONAL APHONIA.—*Case.* Miss H. A. P., a young lady teacher who must use her voice in talking most of the day, complains that for five years she has had sudden attacks of aphonia, which usually lasted from one to three days, and sometimes for a week.

Often the loss of voice was so great that she was unable to carry on conversation without the greatest effort, while at other times the voice consisted of a breathy whisper. The voice was usually suddenly restored, without any apparent cause. She was free from cough, and was not apparently predisposed to colds. She complained of no pain or difficulty of breathing or swallowing. Her general health was not good because of a long-lasting and frequent menstruation, from which she had suffered for a long time; and which was attended by a leucorrhœal discharge. She suffered from headache, especially a dull pain over the eyes.

An examination of the larynx showed the throat to be free from inflammation, but on attempting to close the vocal cords by phonation the cords were seen to close with the greatest difficulty, and could not be sustained in coaptation long enough to produce a continuous sound, but were seen to quiver back and forth and finally become widely opened against the patient's will.

While the intrinsic muscles could be stimulated to contraction by the action of the will power, they could not be sustained in that position but for an instant, hence the extrinsic muscles exerting their full force would quickly draw the cords apart.

The treatment consisted of faradization to the cervical region once in two days for a month, while internally she had calc. carb. regularly, and moschus when she suffered from loss of voice. In two months she was not only free from the aphonia, but had also been restored to perfect general health.

FUNCTIONAL PARALYSIS OF THE EXTRINSIC MUSCLES.—*Case.*—A married lady, aged 20 years, called me at night

in great haste, believing that she was in great danger of suddenly dying from what she thought to be spasmodic croup. I found her slightly asphyxiated, very much frightened and inspiring with the greatest difficulty, while the expirations were less difficult. She had been suffering from this attack, which appeared suddenly, for about half an hour. She had not suffered from cold during the day and her general health was fairly good. She was extremely nervous and crying with fright. An examination of the larynx showed an entire absence of an inflammatory condition, while the surface presented a slightly anæmic appearance. The vocal cords were seen to be held firmly together, which explained the very difficult inspiratory efforts. The firmly-contracting intrinsic muscles held the cords firmly together, while the extrinsic, having lost their power through an emotional paralysis, were unable to separate the cords during inspiratory efforts, but during expiration they were driven apart by the force of the air in the lungs.

A few doses of moschus 2 relieved the paresis and quickly restored the normal action of the larynx.

PARALYSIS OF THE LEFT THYRO-ARYTENOIDEUS.—*Case.*—A. D., age 52 years, clerk, complains that for two years he has suffered from partial loss of voice, with more or less difficulty of respiration. He says that two years ago, while suffering from an acute inflammation of the larynx, he became so hoarse that his voice was quite lost for three or four weeks. About one year ago he suffered from pneumonia, since which time his voice has again been worse, while his general health has not been good.

He has been sent to California, Hot Springs and other health resorts, with the idea that he was suffering from consumption. The family history is good as regards consumption or scrofulous diseases. He has never had syphilis.

The voice and cough are both increased by exertion. He has a wheezing respiration, which is worse on bending forward and relieved by hemming. Cold air causes pain and a sense of constriction in the larynx.

On examination of the larynx the left thyro-arytenoidean muscle was seen to be paralyzed, while the inter-arytenoideus still retained its action. The membranous portion of the left cord was seen to remain fixed during phonation, while the cartillaginous portion attempted to close. The right cord was carried beyond the median line in attempting to join its fellow. The lungs were free from tubercular deposit, while

the cough was purely laryngeal and tracheal. This case illustrates the necessity of perfect diagnosis in larygneal troubles, and shows the serious results that may follow a mistaken diagnosis. Had this unfortunate man been given the proper diagnosis he would not only have saved many dollars but might have saved his voice. Treatment which consisted of causticum internally, and intra-laryngeal faradization, after so long a time was of but slight avail, except for the breathing and the cough.

TUBERCULAR INTER-ARYTENOIDEAN LARYNGITIS. *Case.*— Miss A. C., aged 27 years, suffered from measles six months ago, since which time she has been suffering from the usual symptoms of acute phthisis, hectic fever, night sweats, and rapid emaciation. The most intense symptom, however, is a continual hacking cough, which has persisted in spite of all efforts to relieve it. There is a tickling in the larynx which excites the cough from swallowing, talking, cold air, etc. Deglutition is somewhat painful at times.

There is a pain in the left scapular region and an expectoration of yellow muco-purulent secretion. An examination of the larynx showed a thickening of the inter-arytenoidean space, with an outgrowth in the center about as large as a millet seed, which was exceedingly sensitive.

She was sent to Prof. Arnulphy's clinic where softening of both apicies was diagnosed. Believing the spot between the cords was the great source of irritation, I made applications of chloride of zinc to the thickened surface with the most gratifying results, as she was at once relieved of the harrassing cough, the debilitating night sweats and the hectic fever.

She was so much improved in a month that she was able to go to the Southwest with the hope that the lungs might be restored to health.

It is truly remarkable what serious general disturbances may come from so small an hyperæsthetic spot.

Clinical Reviews.

THE MEDICAL ANNUAL AND PRACTITIONER'S INDEX; A WORK OF REFERENCE FOR MEDICAL PRACTITIONERS. 1890. Eighth year; pp. 600. E. B. Treat & Co., New York.

This single volume has the ambitious design of reviewing what has taken place in the whole field of medical practice that has any claim to newness or revival during the year. It accomplishes much that it declares it will, and gives an epitomé of many subjects that will delight those who wish to "keep up;" such as electro-therapeutics; sanitary science articles, etc. And there is also a list of private hospitals with their locations in the different States, and the class of patients accommodated, and a list of Books for the Year. In this list the new homœopathic works receive a creditable mention, as do the publishers of the same.

It is too much to expect that such a work will be errorless—indeed it is not. In the first division or that of Therapeutics, or review of the therapeutic progress for the year 1889, the very first remedy discussed is actæa racemosa. The case cited was one where ten drops of tincture of cimicifuga twice daily cured a case of dysmenorrhœa of long standing. The reviewer therefore recommends that this drug seems worthy of trial in such cases. It is no new thing in homœopathic practice to cure cases of dysmenorrhæa with actæa. In fact this drug is one of the best proven remedies we have, and one that is reliable when indicated. Its provings were carefully recorded more than thirty years ago, and are known and daily used by hosts of homœopathic physicians.

In the next year-book we shall look to see if the examiner's eye passes sightless over the remedies that *are new* but whose sphere of action are known to a very respectable minority.

E. S. B.

PHILOSOPHY IN HOMŒOPATHY. Addressed to the Medical Profession and to the General Reader. By CHARLES S. MACK, M. D. Cloth 8 vo. pp. 175, 1890. Gross & Delbridge, Chicago.

Doctor Mack has followed the instruction of a celebrated lecturer of Boston, who declared "You must think to the four points of the compass or you do not think at all." The author appeals to philosophy to show the reasonableness and the truth of *similia similibus curenter*, not to the philosophy of homœopathy, but to the philosophy in homœopathy. The argumentative way of presenting the subject suggests that the author had to write this book, and that his pen followed at quite a distance the thought-out and formulated sentences. There are no obscure lines anywhere, nor an uninteresting page. The book will ably serve the purpose for which it was made, to present the foundation and to show off the superstructure of the practice of true homœopathy. The student can look to this book for the answer to so many important questions that arise in his mind when poising just before the entrance upon the study of a system of medicine, and the non-medical public will find a just and reasonable answer to the oft asked question—"Are the claims of homœpathy true?"

E. S. B.

A TREATISE ON ORTHOPEDIC SURGERY. By DRS. E. H. BRADFORD and R. W. LOVETT. Wm. Wood & Co., New York. May, 1890.

In the book with the above title the authors aim at and succeed in impressing upon the reader that, if properly understood, orthopedic surgery deals not only with the cure of deformity, but also with the prevention. With this end in view they have introduced several chapters on diseases of the joints, which all must recognize as being common causes of deformity. Those chapters devoted to the pathology and etiology of chronic joint diseases are especially commendable. Clear, brief and full of the evident desire to escape from the field of speculation with which these

subjects have been vested during the past few years, they make no claims of going into these subjects exhaustively, their desire being to present them in their clinical and surgical relations to the general subject, urging the importance of early recognition and deprecating the too prevalent habit of classing all pains about the joints, lacking a clearly assignable cause as "rheumatic." The anatomical points interwoven with most of the subjects treated, are refreshing and instructive alike to practitioner and student. If the book receives the attention due its merits the demand will be sufficiently large to satisfy both authors and publishers.

H. R. C.

LE MASSAGE DE L'UTERUS. Par le DR. G. NORSTRÖM. Paris, 1889, 8vo., pp. 214. *Uterine Massage*, by DR. G. NORSTRÖM, etc., etc.

Those who have read and utilized this author's very practical monographs on massage in false anchylosis and in the treatment of headache, will be prepared to appreciate this excellent work. It is based upon the details of fifty-four cases, which are given in full, and in which the most pronounced and remarkable results followed the treatment. These cases include certain lesions of structure and of place which the author was careful and competent to recognize, and it certainly adds very much to the clinical value of his work that his diagnosis may be trusted. There are thirty-two cases of parenchymatous metritis; nine of fungous endometritis, in some of which the curette was used as an adjuvant; three of chronic metritis; one of subinvolution; four of prolapsus of the womb, the vagina and the bladder, and several of uterine fibroids, in which the massage relieved the associate symptoms very decidedly. Chapter X is devoted to the technique of this mode of treatment, the precautions to be taken, its difficulties and its contra-indications.

R. L.

CONTRIBUTIONS TO THE SURGICAL TREATMENT OF TUMORS OF THE ABDOMEN. Part II.—*Electricity in the Treatment of Uterine Tumors.* By THOMAS KEITH, M. D., LL. D., Edin.,

and Skene Keith, f. r. c. s., Edin. Edinburgh, 1889, pp. 225.

When Part I of this work appeared we were delighted with the authors' advocacy of hysterectomy, in which operation, by the abdominal method, he had had an unparalleled success. But now the tables are turned, not tipped, in favor of treating the incidental symptoms by Apostoli's method, leaving the tumors to take care of themselves. Part II is based upon the clinical history and treatment of 106 consecutive cases of uterine fibroids, which are given in detail. The number of treatments, the dosage, etc., are also recorded most carefully. Nothing can be more expressive than the following extract from the "Introduction" to the work:

"It must also not be forgotten that the cases treated were the worst possible, both as to the size of the tumor and the severity of symptoms. We will probably never again have such a series of bad cases to treat. Those who have practiced ovariotomy only during the last twelve or fifteen years, know little what the operation was twenty-five or more years ago, in the early days of abdominal surgery. When patients with uterine tumors come for treatment by electricity at an earlier age than they do now, then may reasonably be expected the same ease of cure as is now the case in ovarian disease. The need for the removal of ovaries for small uterine tumors and of hysterectomy for large ones—except in the rare form of fibrous-cystic tumors—will then pass away. No large uterine tumor has with us entirely disappeared under the electrical treatment, but in four cases of small fibroids, three of which come into the present series, there is not now a trace to be found. Doubtful cases of simple enlargement have been excluded altogether, though in every one of these the result has been perfect.

"The carrying out of this treatment faithfully to the end is not an easy matter, and old tumors that are large, and that have bled for many years, take a long time to improve. The treatment runs away with time, and it requires care and thought. To the surgeon, by far the simpler plan is hysterectomy and the removal of the ovaries. But Dr. Apostoli's treatment saves our patients from risk of life by operation, and saves them also from a horrid mutilation—

the one thing that they all dread. We believe it to be the right treatment, and our patients must get it, however great the inconvenience and monotony of it may be to ourselves. Though our results after hysterectomy show the lowest mortality of any yet recorded, and though we have had but a single death after removal of the ovaries for fibroid in almost one hundred operations, we reject even the minor operation in favor of Dr. Apostoli's treatment, and we reject hysterectomy altogether on account of the mortality that has hitherto attended it all over the world. The method given us by Dr. Apostoli is good, and it will endure. We have no fear now of its passing away and being forgotten."

We have already insisted in these pages that the true value of electricity in gynecology could only be determined by men of large experience and of undoubted integrity. Both these conditions are met in the case of Dr. Keith and his talented son; and it is a compensation that, while they have largely withdrawn from operative work in abdominal surgery, they are willing to devote themselves to setting us right in kindred matters. Even Apostoli's first experience had to be taken with a pinch of salt, for he was neither a specialist in gynecology nor a surgeon of any kind; and as for a host of those who have hitched their car to his theory their evidence is worthless because they do not really know what they are talking or writing about.

This book does not discuss the mode of applying electricity in uterine tumors but is wholly occupied with the history of cases and the results of their treatment by Apostoli's method.

R. L.

CORRESPONDENCE.

We venture to season our midsummer issue with two spicy and suggestive letters, premising that there was no vinegar in the ink with which they were written, and that nobody need go into a state of mind if he does not like their flavor. The first is from the Secretary of the Leavenworth City Board of Health.

LEAVENWORTH, Kansas, June 9, 1890.

Dr. R. Ludlam, Editor of the CLINIQUE:—

DEAR DOCTOR—I occasionally see a copy of your journal and in looking over the number for April 15, I read and was greatly pleased with the address of F. W. Gordon, M. D., but if allowable, I wish to take issue with him on one point regarding which most physicians are very sensitive, and that is the distinctive name that many apply to themselves. I would like to ask the Doctor to define a homœopath. If he is one who believes in the law of "*similia similibus curantur*" and bases all his practice on that, well and good, he is a homœopath; but instead of enjoying an advantage over those whom he deems opponents, whom I prefer to call simply "physicians," not "homœopaths," he is at a disadvantage, for we of the non-homœopathic faith do not disclaim any such law, we believe it and "acknowledge it through press and prescription," while at the same time claiming that there are *other principles* applying in the cure of diseased bodies that a physician cannot afford to neglect.

As I look further down his address I see that the Doctor believes "Old-School medicine is not all a farce," and it occurs to me that the Doctor's belief and my own are identical. Why, then, does he speak of the class to which I belong as "opponents?" Simply because I call myself a *physician*, while he calls himself a *homœopathic physician*. Who is keeping up the fight that is a disgrace to our noble profession? Is it the one who claims that everything which will cure disease is to be used in its relief and sails under such colors, or the one who says he is an eclectic or a homœopath, while admitting that neither designation covers completely his articles of faith?

It is easy to see from the tone of Dr Gordon's address that he is a broad-minded man, but it strikes me that he approaches his subject biased by the reports of olden times or the fol-de-rol of some crank of the present day. Let me state as a graduate of the Harvard Medical School and as voicing the sentiments of many of the best men in the medical profession of to-day, that our desire is to see the medical profession united and the division into the so-called schools done away with. That "like cures like" in the sense laid down by Hahnemann, is be-

lieved by a majority of all physicians, but I cannot, on account of my belief in such a doctrine, say that I am a homœopath, for I believe that water, in its various modes of application, relieves many troubles; therefore I am to that extent a hydropath. I employ electricity in practice, therefore am I an electropath. Those who are not homœopaths oppose your distinctive name, which, according to your admission, as I have pointed out, is not strictly honest.

True, in asking homœopaths to lay aside their name more is asked of them than of the so-called "regular" school, for a study of history will show that the homœopaths gave the name "allopaths" to those who were not of their mind, and by this name they were long known; but that later on, admitting the incompleteness of any such term, they adopted the title of "regular" to distinguish themselves from homœopaths and eclectics. These differences in name will be done away with sooner or later, and that time is postponed by those who refuse to come half way.

The regular school is more ready to drop its title than any other. Their patients do not all die. They do not treat all cases by administering quarts of nauseous medicine, but in point of fact there is as much resemblance between the treatment of an individual regular and an independent homœopath as there is between two individual homœopaths in different sections of the country.

I have given this matter some study and am prepared to state that the men most virulent and fanatical are the narrow-minded, under-educated ones and that the more extensive a man's knowledge the less he makes of these petty distinctions.

Now in medicine, unlike politics, the best men are the most prominent, and have the most power; why is not the present a good time for these men to urge the dropping of distinctive terms for the benefit of mankind and of our profession? As well might two lawyers be opponents of each other because one is a criminal the other a corporation lawyer. The cases are parallel, all precedents are at the disposal of each, but one employs a certain class more than another.

Pardon me for running on in this way, but I am only one of many who hope to see union brought about between these unnecessarily opposed classes, and I trust you will see fit to publish this, in full or digested, to that end.

Fraternally yours,

WALTER D. BIDWELL, M. D.

CHICAGO, July 3, 1890.

MR. EDITOR:—In the *Atlantic Monthly* for July I find that our old friend, Dr. Oliver Wendell Holmes, indulges *Over the Teacups* in one of his old-time flings at homœopathy. As usual, however, his unkind talk is offset by a commendable liberality in other directions, for he comes to the rescue of the Jews at the hands of the Christians with the most wholesome reproof. What a pity that his charity is not of the all-round

sort that shines in the Sermon on the Mount. Let me give your readers what he says for the Israelites in one column, and what he might consistently have said for our school of medical practice in another:

RELIGIOUS TOLERATION.	MEDICAL TOLERATION.
1. It seems as if there should be certain laws of etiquette regulating the relation of different religions to each other.	1. It seems as if there should be certain laws of etiquette regulating the relation of different physicians to each other.
2. It is not civil for a follower of Mahomet to call his neighbor of another creed, a "Christian dog."	2. It is not civil for a follower of Hippocrates to call his neighbor of another creed a "miserable quack."
3. Still more, there should be something like politeness in the bearing of Christian sects toward each other, and of believers in the new dispensation toward those who still adhere to the old.	3. Still more, there should be something like politeness in the bearing of medical sects toward each other, and of believers in the old dispensation toward those who adhere to the new.
4. We are in the habit of allowing a certain arrogant assumption to our Roman Catholic brethren.	4. We are in the habit of allowing a certain arrogant assumption to our "Old-School" brethren.
5. We have got used to their pretensions.	5. We have got used to their pretensions.
6. They may call us "heretics," if they like.	6. They may call us "quacks," if they like.
7. They may speak of us as "infidels," if they choose, especially if they say it in Latin.	7. They may speak of us as "frauds," if they choose, especially if they say it in Latin.
8. So long as there is no inquisition, so long as there is no *auto da fé*, we do not mind the hard words much; and we have as good phrases to give them back: the Man of Sin and the Scarlet Woman will serve for examples.	8. So long as there is no social or scientific inquisition, so long as there is no professional Phariseeism, we do not mind the hard words much; and we have as good phrases to give them back: the "old fogy," and the "horse doctor" will serve for examples.
9. But it is better to be civil to each other all round.	9. But it *is* better to be civil to each other all round.
10. I doubt if a convert to the religion of Mahomet was ever made by calling a man a Christian dog.	10. I doubt if a convert to the method of the "old-school" was ever made by calling a man a "medical impostor."

11. I doubt if a Hebrew ever became a good Christian if the baptismal rite was performed by spitting on his Jewish gabardine.

12. I have often thought of the advance in comity and true charity shown in the title of my late honored friend, James Freeman Clarke's book, "The Ten Great Religions."

13. If the creeds of mankind try to understand each other before attempting mutual extermination, they will be sure to find a meaning in beliefs which are different from their own.

11. I doubt if a Homœopath ever became a good Allopath if the baptismal rite was performed by spitting on his pocket-case of remedies.

12. I have often thought of the advance in comity and true charity shown in the title of my late honored friend, Dr. Carroll Dunham's address at the meeting of the American Institute of Homœopathy, (the oldest National Medical Society in America) held in Chicago in June, 1870: "*Freedom of Medical Opinion and Action, a Vital Necessity and a Great Responsibility.*"

13. If the medical creeds try to understand each other before attempting mutual extermination, they will be sure to find a meaning in beliefs which are different from their own.

Believing with the Autocrat of the Breakfast Table, that "the great thing in this world is not so much where we stand, as in what direction we are moving;" I beg leave to sign myself,

A VETERAN.

Miscellaneous Items.

SEVENTY-TWO physicians, alumni of the "Old Hahnemann," had a pleasant reunion during the Institute Meeting in Waukesha.——The thirty-first Winter session in the Hahnemann Medical College and Hospital of Chicago will open with an introductory lecture by Prof. Halbert, on Tuesday evening, Sept. 16.——Dr. Mary C. Shibley is convalescing from typhoid fever.——Dr. G. H. Weeks has removed his office to 3847 State St.; Dr. J. A. Hoffmann, do., from Osage, Iowa, to Oak Park, Ill.; Dr. S. H. Quint, do., to 633 Market St., Camden, N. J.; and Dr. H. H. Jewell from West Concord, Vt., to Nashua, N. H.——Dr. Ada B. Runnals has located at Canton, O.——The deaths for the month include that of our old and valued friend, Dr. John Meyhoffer, of Nice, France, where he had practiced since 1857, and of Dr. Lewis Dodge, of Adrian, Mich., June 25.——Two of our last year's alumnæ, Drs. Isaac Clark Soule and Adelaide Goodrich, were married July 5, and will reside in Pullman, Ill.——Dr. J. C. M. Drake, '79, was married June 16th to Miss Cassie Crouch.——*On dit* that of the 110 newly elected members of the Institute, more than one-half were graduates of the Old Hahnemann of Chicago.——We are in receipt of a new and attractive medical journal, the *Medical Argus*, which is in charge of our friend, Dr. F. F. Cassidy, of Kansas City.——Robert H. McMurdy, Esq., of Chicago, has been elected Professor of Medical Jurisprudence in the Hahnemann.——The Twenty-fourth Annual Report of the Homœopathic Medical and Surgical Hospital and Dispensary of Pittsburgh, Pa., for the year ending March 31, '90 makes a fine exhibit of a most flourishing and popular institution.——The Boston Homœopathic Hospital has received a gift of $120,000 from the State of Massachusetts.